FY 1999 - 2000
Accountability Report

October 17, 2000

Mr. Les Boles
Director, Office of State Budget
1122 Lady Street, 12th Floor
Columbia, S.C. 29201

Dear Mr. Boles:

Enclosed please find the Department of Mental Health's FY 1999-00 Accountability Report as required by Sections 1-1-810 and 1-1-820 of the 1976 Code of Laws.

As you know, DMH is a large, complex agency serving a wide range of clients including persons with serious and persistent mental illness, forensic services, emotionally disturbed children, adolescents and their families, elderly persons in need of nursing home care (including veterans), persons with alcohol and/or substance abuse, and several other special populations. In FY 00, over 90,000 consumers were served by the Department's seventeen (17) community mental health centers, and approximately 14,000 were served by the agency's inpatient facilities.

In this report, we have attempted to address the agency's activities based on the Malcolm Baldridge performance excellence criteria including Leadership, Customer Focus and Satisfaction, Program Outcomes, Human Resources, and Information and Analysis. Much of the Department's focus for the past few years has been on the development of specific program outcomes and cost and measuring customer (consumer) satisfaction.

I hope you will find the agency's Accountability Report informative and useful. If you have any questions or need additional information, please contact Mr. Jack Balling at 898-8513.

Sincerely,

James H. Scully, Jr., M.D.
Interim Director

Executive Summary

The Department of Mental Health has positioned itself to effectively address the Malcolm Baldrige Quality Criteria as a result of its focus on mental health treatment innovation and on consumer perception of care, which includes consumer outcomes and satisfaction. The attached report provides an overview of the activities of the department in quality criteria format. This executive summary highlights some of the features of the attached report.

Behavioral Healthcare in the most recent five years has taken steps toward the development and implementation of outcomes monitoring for policy, quality and service accountability reasons. The Behavioral Healthcare field has been well served by this initiative. Specifically, mental health systems nationwide have collaborated to produce comparable quality, satisfaction and accountability data. The result of this effort is an emerging and unparalleled (49 of 50 states) bench marking effort. The South Carolina Department of Mental Health has been involved from the beginning; indeed, we have taken a leadership position in this effort. This year the system has matured to the point of producing data which is benchmarked with similar facilities and centers on the national and state levels. The South Carolina public psychiatric facilities, which are Joint Commission accredited, compare favorably on patient safety issues with similar facilities in other states. A more complete discussion of the results of consumer care are contained in the attached report.

The basic question is "Does the department listen to its consumers?" Consumer perception of care is the hallmark of the accountability and satisfaction data used by the department for adults served in the community. Department staff are involved in the creation of instruments to capture inpatient consumer perception of care and the first data from this process has been used for quality improvement during this year.

In the healthcare service industry, a trained and competent work force is a must for a quality organization. The Center for Innovation of Mental Health Policy was established this year under the agency's Division of Education Training and Research. The Center couples policy development, basic training and educational support for new service initiatives with the necessary resources for statewide delivery of the training.

Stigma associated with mental illness persists in South Carolina. This statement is supported by data from a statewide study which we conducted during this past year as well as the Surgeon General's recent report on mental health. The Department undertook to impact these mis-perceptions with a campaign "Mental Illness, Its Not What You Think." Effective public service announcements and involvement by many people, who care about persons who are mentally ill, as media watchers are changing the public perception of mental illness. This is important work which has grown as a public/private citizen partnership during this year.

Quality services to persons with mental illness have been continued this year with further enhancements in selected areas. While long term psychiatric services in both the inpatient and outpatient areas has been maintained, the recent funding waves of community transition programs like the agency's "Toward Local Care" (TLC) Initiative have improved the lives of patients by supporting these citizens in their home communities. These most recent TLC waves have built upon more than a decade of focusing on seriously and persistently mentally ill consumers successfully served in the community.

Recently, forensic services have become most challenging for the Department. The challenge results from court and legislative mandates to serve mentally ill/behavioral disordered persons previously served in the prison system. Forensic services are the area of fastest growth with inpatient census increases in DJJ subclass children and adolescents, persons determined to be Not Guilty by Reason of Insanity, and Sexually Violent Predator civil commitments. While department staff have improved programs and skills to meet the clinical needs of these groups on the one hand, the growth in numbers of persons served for forensic reasons has required additional resources to meet this demand. The State of South Carolina has been pressed to meet the diverse needs of mentally ill/behaviorally problematic people who have come into contact with the prison system. The State has moved to increase the role of the department in meeting these needs. The department has provided quality services in the face of additional mandated services to persons previously served by the Department of Corrections and Department of Juvenile Justice.

In a time of leadership change within the Department, consumer satisfaction with services remains the driving force in policy, service delivery, and performance improvement. From reducing the stigma of mental illness, to meeting the needs of consumers in their home community, to measuring and improving the quality of the agency's services, the voice of the consumer is central to our work.

For two decades we have been dedicated to moving our service delivery system to the community. Mental health consumers do live and work in local communities. Our successes are measurable. Our data is benchmarked nationally, gathered statewide, consumer driven/conducted, and used to improve the effectiveness and efficiency of the services.

Ours is a message of hope and recovery.

The South Carolina Department of Mental Health
OUR MISSION

The men and women of the S.C. Department of Mental Health, in partnership with consumers, families and their diverse communities, will assist citizens with mental disorders to improve the quality of their lives.

OUR PRIORITIES

The department will give priority to adults and children with serious mental illnesses and serious emotional disturbances and will fulfill its legislative mandates. We will work cooperatively with other agencies, both public and private, to assure continuity of services based on the needs of the individual.

OUR VALUES

Respect for the Individual

We believe that the people we serve have the right to personal dignity, respect and the highest possible degree of independence. We are committed to services that promote the individual's quality of life, focus on the individual's strengths, foster independence, and honor the rights, wishes and needs of the individual.

Support for Local Care

We believe that people are best served within their home community. We are committed to the availability of a full and flexible range of coordinated services with the community as the primary focus of care, and services that appropriately meet the needs of the individual in the most normal environment possible. We are committed to programs which build upon the local support provided by family, friends, other agencies and the community, and which offer employment, leisure, learning, residential and psychiatric/rehabilitation services within this supportive framework.

Professionalism and Commitment to Quality

We believe that we should encourage and reward excellence. We will create a work environment which inspires and promotes innovation and creativity, supports education and research, and continually seeks more efficient and effective ways to provide clinical and administrative services. We are committed to a skilled and ethical work force, culturally competent and dedicated to the highest standards of courtesy, understanding and respect. We will be an agency worthy of the highest level of public trust.

LEADERSHIP SYSTEM

The DMH is governed by a seven member board which is appointed by the Governor with the advice and consent of the Senate. Members serve five year terms. The Mental Health Commission is responsible for the hiring of the state director. The Commission determines policies and adopts necessary rules and regulations governing the operation of the agency and the employment of professional and staff personnel.

Under the direction and leadership of the state director, the department has established several leadership bodies to ensure that the policy and operational directives of the governing board are translated and communicated throughout the agency. A senior management group meets weekly and membership includes the state director, the deputy directors for administration, clinical services and quality assurance, the general counsel, the state director's executive assistant, directors of communications, community services, childrens services, public safety, and the director of corporate compliance. The decisions of this group are communicated to the directors of the 17 community mental health centers and the six inpatient facilities for implementation. In addition, the community mental health center directors and the facility directors meet monthly to discuss issues of common concern. Finally, the Governing Body for Inpatient Facilities is responsible for clinical and patient care issues and for credentialing of medical staff.

During the year, departmental leadership underwent a striking redevelopment. Six new members were named to the SC Mental Health Commission; the State Director's position was vacated and an Interim State Director currently serves in that capacity; and three of six inpatient facilities are under new management. In addition, the Deputy Director of Clinical Services position was filled and one community mental health center director replaced. Throughout these changes, the Department has continued its commitment to quality services. The new leadership is markedly comprised of people who have risen through our ranks and have a great deal of insight into the workings of the department and its role in the state.

During FY 00, the agency undertook an effort to change public thinking and perceptions of mental illness in an anti-stigma campaign centered upon the theme, " Mental Illness, It's Not What You Think." The campaign qualitatively sets forth a value and belief supported by our experience that consumers do recover from mental illness. **It is a message of hope and recovery.** The campaign was supported by a study of the public perception of mental illness in South Carolina and led the department to include goals for better, more accurate information about mental illness and its effects. In support of this initiative, the legislative liaison and public relations functions of the agency were merged into one unit; a media watchers program of citizen participation in correcting factual errors about mental illness in mass media was initiated; and a program was developed to inform future journalists, while they are still in training in colleges and universities, about the facts of mental illness and to sensitize them to mental illness or what its like to be a family member or loved one of someone who has a mental illness.
The DMH mission statement emphasizes the agency's commitment to several key values which impact on the quality of care that we strive to provide to our clients. The leadership of the department seeks to create an environment which inspires and promotes innovation and creativity, supports education and research and continually seeks more efficient and effective ways to

provide clinical and administrative services. We believe in developing a skilled and ethical workforce, which is culturally competent, and dedicated to the highest standards of courtesy, understanding and respect.
The senior leadership of the department has instituted a continuous performance and outcome system that measures the effectiveness and cost efficiency of the agency's many programs. This system is centered around consumer-based outcomes, a main priority. This outcome system allows leadership to monitor and document the quality of programs and the benefits and positive impact of them on the clients that we treat.. The system also allows us to ensure that we incorporate the input of the consumer and their family members through self-reporting of their satisfaction with our services. The DMH has also instituted a clinical practices coordinating body to ensure that all services are provided in a manner which emphasizes clinical "best practices".

The department has placed great importance on the training and development of its employees and their involvement in the decision making of the various facilities and centers. Each center and facility has a management team. There are self-identified consumers on the management teams of these facilities who provide policy and planning advice from the consumer perspective and ensure that the management team is always cognizant of the needs of consumers. A pilot mentoring program has been set up by the department to allow selected employees to receive exposure to the decision making process and to develop promising future leadership. Finally, the efforts of the Education, Training and Research division to re-energize the staff development function continues. Through quality pre-service education, continuing education and training programs that enhance employee performance, recruitment and retention of qualified employees, and the commitment to applied research, the DMH believes that employees will be well prepared to face the challenges of the future.

CUSTOMER FOCUS AND SATISFACTION

The Department of Mental Health has made the consumers and their rights the center of focus for South Carolinians who suffer from mental illness. Consumers and their advocates have had a positive impact on the policies adopted by the department and, in a more personal way, the treatment received. The Department of Mental Health has provided for both of these types of input in its decision process. From the State Plan Committee, to the Center Boards, to the Toward Local Care Committee and to the Strategic Planning activities, consumers and advocates are found in leadership as well as full committee membership capacities at all levels of planning. Primary consumers have been hired by community mental health centers and facilities and provide consumer representation as day-to-day decisions about care and policy are being made. The department listened carefully to the primary consumers when designing the system of outcomes now in use in the department. In summary, the consumer is embedded in the planning and administrative structure of the department.

The department is fortunate to have an active advocacy community for mentally ill persons in South Carolina that extends consumer-centered services well beyond the formal and informal methods found in the department itself. In the decade of the 1990's, the mental health advocacy community has taken an active role in policy development as the organization's membership has broadened and become well informed. Cutting edge information on mental illness and treatment, including new drug therapies, are put in the hands of the primary consumer, their families, and their advocates. Health issues are the largest segment of accessible sites on the Internet including the agency's own web page which features current information about mental health services focused on the consumer.

The consumers voice has been heard in the treatment of individuals. The department has provided for the use of Advanced Psychiatric Directives that put in writing the experience and choices of the consumer to be used in times of psychiatric emergency. The voice of the consumer is heard through consumer-to-consumer satisfaction teams which build on the common bond formed by people that have common illnesses. The consumer's voice is heard in recently identified trauma and recovery initiatives that are recognized in South Carolina as important factors in the treatment of mental illness. The consumer's voice is heard in publications like "In Their Own Words" that frames illness in personal terms and impacts the stigma associated with a mental illness. The department has invested personnel and resources in getting and maintaining each of these on-going ways of assessing satisfaction with and input for a system that grows around a consumer focus.

Consumer-to-consumer interviewing exemplifies the department's regard for consumer centered data collection. The department has identified this method as one of the most effective and empowering ways to gather data of this nature. The mission of the initiative is to "involve individuals who receive services, family members, independent advocates and citizens-at-large in program evaluation and continuous quality improvement of the Department of Mental Health." The project is entirely consumer-driven and run by primary consumers. To measure the indicators of access to services, the appropriateness of services, outcomes of service, and service satisfaction and dissatisfaction, consumer-to-consumer processes are nationally regarded as best

practices.

The results of the center surveys thus far have been positive overall. Eighty-two percent to ninety-eight percent of consumers surveyed reported that they would recommend the services to a family member or friend if they were in need of the services.

After the interviews, team members meet and debrief with front-line staff. This approach lets staff know what parts of a given program need improvement. The front-line staff is also informed of areas which satisfy consumers. In this way, both consumers and staff have input, and everyone works together to improve the quality of services.

The Consumer-to Consumer Evaluation Team was also hired to conduct the Mental Health Statistics Improvement Project (MHSIP) Consumer Survey, a nationally utilized instrument for measuring consumer perception of access, appropriateness, and outcomes of services. Results of this survey reveal that 81 percent of consumers surveyed agreed that access to treatment was adequate, 82 percent agreed that care was appropriate, 79 percent agreed that the outcome of services was adequate, 84 percent were satisfied with services, and 79 percent agreed that they had adequate involvement in their treatment planning.

The Department continues to be committed to promoting customer service in all its functions. All of the centers and facilities have some mechanism in place to obtain satisfaction information from consumers on a regular basis. This information is used for a variety of purposes including quality improvement, planning and decision making, and accreditation reporting. The department began an effort to standardize the process somewhat by identifying two satisfaction questions that will be asked uniformly statewide on all center and facility surveys. When the data is analyzed, it can be implemented statewide.

OTHER PERFORMANCE EXCELLENCE CRITERIA

Information and Analysis
Our commitment to data-based decision making and service provision is seen in the continued

implementation of the medication control and information system (QS1) in all inpatient facilities, expansion of the DMH Web page and the availability of effectiveness and efficiency information to users via the agency's Intranet. Budget information, time keeper reports, expenditures and clinical outcomes of service are included in this information warehouse that has come into daily use during this past year. We have put technology to work by putting information in the hands of those who need it. Development of the report writer function of Information Resources and other divisions has made data available to consumers and front line clinicians, as well as the Legislature and Governor's Office.

The need to address the potential Y2K problem led the department to make a significant investment in computer desktop hardware, replacing many out of date computers. This investment was required to make all network computers Y2K compliant. The non-compliant computers have been relocated within the Department for DMH consumer use in "stand alone" applications. This utilization furthers consumer technology skills, increases their knowledge of medications and simulates the use of "like home" computer applications. Mental illness does not know intellectual boundaries. Our consumers will not be left behind if we provide this avenue for computer-based education and computer skill development.

Human Resources

A step forward in the development of intellectual resources in the department was the establishment of the Center for Innovation in Public Mental Health Policy, which is part of the agency's Division of Education, Training and Research and the USC School of Medicine. Additionally, there has also been a rapid increase in the number of training activities directly related to current departmental initiatives. Cultural Competency, clinical practice updates, best practices, Continuing Medical Education, and basic DMH training modules have been undertaken by the Center for Innovation through a developing relationship with the South Carolina Educational Television Distance Learning facilities.

In addition, the Center has been designated a role in policy development. An example of this is the evaluation of the agency's role in treating persons with mental illness who are still in the prison system and the provision of an adequate link to outpatient services after release from prison.

The first class in a recently implemented Mentor Program finished its studies during this past year. The program focused on development of persons who are under-represented in the management of the department.

Nursing staff and mental health specialists were granted salary upgrades to help the department remain viable in the labor market and to enhance its recruitment and retention efforts.

Quality Services and Programs

The department has consistently stated its commitment to returning consumers to their home communities. Since the early 1980's, the department has developed and expanded programs to return long term hospital patients to the community and has done so with success. In the mid-1990's, the department re-engineered its services/providers into service networks and other tested best practice models to assure a continuum of services and programs which support persons with serious mental illnesses to live successfully in the community. This effort is ongoing. We are

well along the way but have not completed this task of serving consumers in the community setting rather than the more expensive care in centralized hospitals. The department continues to further its Toward Local Care initiatives.

In the mid 1990s, services for children and adolescents and their families were central issues in DMH budget requests. Family Preservation, Juvenile Justice Status Offender Diversion, Futures, and School Based Services programs are successful, focused, outcome-oriented programs. Budget and personnel issues, however, have limited the growth of these tested program models.

The third major program area for the state public mental health authority is stabilization of persons experiencing psychiatric crisis. During FY 00, the department funded 34 programs in locations throughout the state dedicated to treating persons close to their home, stabilizing the psychiatric crisis, and supporting the individual as they recover from mental illness. The therapeutic effect of treatment close to home serves to lessen the time spent in costly inpatient care.

The fourth program area is forensic psychiatry. DMH has experienced a growth in forensic population.

- The state-mandated Sexual Behavior Treatment Program that provides treatment for sexually violent predators has increased from two to twenty-one patients during this past year.
- The Allen project, which serves Not Guilty By Reason of Insanity patients, saw an increase in persons served on campus as the result of a court decision that abolished "passes" from the wards.
- The department has added two specially trained forensic psychiatrists to the inpatient units, which do forensic evaluations and direct forensic patient psychiatric rehabilitation.
- The department moved to better treat and monitor offenders by aggregating forensic patients (except sexually violent predators) into one facility.
- The department has researched best practices for serving consumers in county jails and in the community after release and has completed a data based Community Outreach Program (COP) approach to the problem.
- The state entered into a Department of Juvenile Justice consent decree several years ago for children and adolescent with mental illness housed in DJJ. This continued to be an obligation.

Through our long standing programs and through current state identified needs, the department has developed skills and programs that serve state forensic needs and the psychiatric needs of primary consumers involved with the legal system.

Performance and Results

For more than two decades the department has been moving to a more community-based system of care and a reduction of dependence on inpatient services for the citizens of the state. In line with that continuing goal, the department reduced the number of persistently mentally ill persons served in its long term psychiatric hospital. The number of persons in the Psychiatric Rehabilitation Program (State Hospital) decreased from 367 to 311.

A planned decrease in the census of long term nursing care, from 591 to 501 patients, has allowed the department to vacate a building wrought by water and physical systems problems.

The South Carolina Department of Mental Health continues its commitment to an extensive consumer-centered outcome initiative that reflects the its priority for consumer involvement, consumer perception of care and consumer-led evaluation. Utilizing a varied approach for data collection, the department maintained its core value of putting the consumer at the center of outcomes and performance measurement. We will know we are reaching our vision when our data is viewed as clear, credible and consistent by external groups.

During the past year, the department has focused efforts on the collection of system-wide performance data for baseline outcomes. The goal was to create data which was consumer-centered, measured variables of interest to consumers, stakeholders, and service providers, and which used measures common to all programs providing similar services across the system regardless of location. The measures selected for use in the outcome system include those which are based on consumer perception and response, which appeared to have clinical relevance to our treatment settings, and which have clinical utility.

The department continued to collect data for a number of key performance indicators, specifically reflective of consumer perception. These indicators include: access to services; the appropriateness of services; outcomes of service; service satisfaction and dissatisfaction; reduction of symptoms; improvement in functioning; level of empowerment; and reduced stigma related to mental illness. Consumers report fewer problems, reduced symptoms, appropriate services and higher functioning during receipt of services.

In January 2000, the Office of Quality Improvement/Outcomes produced the first system-wide Program Outcome and Cost Reports for the previous year. This management information was used to analyze program effectiveness and efficiency . This first attempt to capture baseline data allowed for comparisons across programs and bench marking on the national level. The Outcome and Cost Reports proved to have a variety of utilities including providing information for legislative oversight, advocacy organizations and service analysis. Outcome and cost data are now available to centers and facilities electronically from the department's Client Information System.

The department has a four-year history of bench marking selected performance indicators with fifteen other states. The department uses indicators that are consistent with those used nationally. This will give the agency the ability to compare our mental health services with similar services offered across the country. The performance indicator system has used input from consumers, family members and other advocates. It is only by drawing on this input and involvement, that a performance indicator system can be developed which is reflective of the priorities of consumers, family members and other key stakeholders. The department has a performance indicator system that gives clinicians and consumers information on best practices for mental health services. This will help prioritize services, allocate limited resources, and most importantly, result in better services. The Department is committed to a performance and outcome system that is accountable to all stakeholders, and that accountability must be based on valid, reliable and

comparable data.

The agency's hospital programs are required by national accreditation bodies to participate in performance measurement systems. This will produce the ability to benchmark critical measures of performance and outcome with the best facilities nationally and lead to the identification and implementation of processes that ultimately improve client outcomes. The first several months of analyzed data from this process show that the department compares favorably with similar facilities nationally.

PROGRAM NAMES

Although programs and program outcomes are reviewed and assessed, DMH still vests fiscal responsibility at the hospital and mental health center level. It is generally difficult to determine a priority ranking among facilities, however our community mental health centers and acute inpatient hospitals remain the centerpiece of our system. The following "programs" are used in the annual appropriations process:

1 -- Community Mental Health Services

2 -- Acute Psychiatric Hospitals
G. Werber Bryan Psychiatric Hospital
Patrick B. Harris Psychiatric Hospital

3 -- William S. Hall Psychiatric Institute

4 -- Psychiatric Rehabilitation Services
SC State Hospital

5 -- Morris Village

6 -- Byrnes Center

7 -- Tucker/Dowdy Gardner Nursing Care Center

8 -- Campbell Veterans Nursing Home

9 -- Intermediate Care Facility (ICF/MR)

10- Sexually Violent Predator Treatment Program
(Behavioral Disorders Treatment Program)

PROGRAMS:

Program Title: **Community Mental Health Services**

Program Rank: **1**

Program Cost:

State	**$56,344,966**
Federal	**$5,269,310**
Other	**$66,268,884**
Total	**$127,883,160**

Note: Figures represent direct costs only, excluding Fringe Benefits and other DMH-allocated expenditures

Program Goals: To provide an array of community-based mental health services to adults with serious and persistent mental illness and emotionally disturbed children and their families including emergency services, community support activities and general outpatient services; and to provide general operational support to a system of 17 community mental health centers and their clinics and outreach programs

Program Objectives:

1) to expand local crisis stabilization capacity within local community mental health centers;

2) to maintain and expand client transition to local community services from clinical inpatient facilities based on evaluation and monitoring current Toward Local Care (TLC) programs;

3) to improve the community care of citizens with serious mental illnesses by increasing employment opportunities that are commensurate with client's interests, skills, and abilities; 4) to increase housing in under-served areas for clients with serious mental illnesses by working with non-profit organizations and advocacy and consumer representatives focusing on how to get consumers more involved in housing initiatives;

5) to ensure that children and their families have every treatment service available and accessible to them on either a local or regional basis. To support family involvement in treatment by making services more available in terms of physical proximity, service delivery sites and innovative program operational procedures and practices, to include out stationing or integrating services into other human service agencies. To promote the expansion of prevention and/or early intervention services aimed at decreasing the need for more intense and costly crisis or long-term residential services;

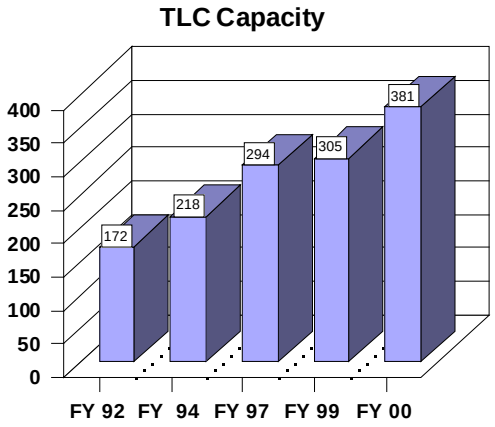
5) to maintain accreditation of all mental health centers and enhance our ability to measure program cost and outcomes;

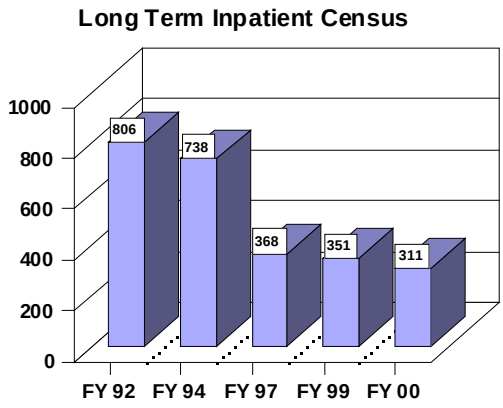
5) to improve community mental health services and inter agency collaboration of services for pre and post trial offenders with mental illness.

Program Results:

1. In FY 00, DMH funded 34 Crisis Diversion projects in 15 of the 17 center catchment areas. At the end of FY 00, 30 projects were fully operational and reported 1,859 diversion contacts with 1,405 (76%) successful diversions from hospitalization. Upon full implementation, the projected target is 1,929 diversions from hospitalization;

2. At the end of FY 00, Towards Local Care capacity was 381 clients. An additional 12 TLC proposals were awarded to mental health centers on an RFP basis for FY 01 which will increase the TLC capacity to 500 and result in every mental health catchment area having at least one TLC project;





3. The primary outcomes for children being served are those most relevant for families–*to keep their children at home, in school and out of trouble*.

Acute Psychiatric Inpatient Hospitals

Program Title: G. Werber Bryan Psychiatric Hospital

Program Rank: 2-a

Program Cost:

State	**$16,146,711**
Federal	
Other	**$3,539,092**
Total	**$19,685,803**

Note: Figures represent direct costs only, excluding Fringe Benefits and other DMH-allocated expenditures

Program Goals: To provide short-term intensive services to residents ages 16 and older who live in its 33-county service area

Program Objectives:

1) to return residents to their communities as quickly as possible;
2) to maintain continuity of care for residents by coordinating with community agencies;
3) to retain highly trained and qualified staff;
4) to provide high quality service that meets our customers' satisfaction; and
5) to maintain national accreditation (JCAHO) and federal certification (HCFA)**.**

Performance Measures

Workload	**FY97**	**FY98**	**FY99**	**FY 00**
Total patients received	4,575	5,199	5,472	4,513
Total patients separated	4,593	5,203	5,431	4,529
Average Daily census	207	208	228	212
Year end census	198	209	248	195
Functional Bed Capacity	242	242	242	242
Efficiency:				
Facility cost per patient day	$337.65	$346.09	$265.20	$343.43
Average length of stay (discharges)	16.9 days	14.8 days	12.5 days	17.6 days
Cost of average length of stay	$4,565	$4,240	$3,315	$6,044
Occupancy Rate (census/beds)	86%	86%	94%	88%

Program Results:

- Hospital fully accredited by Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for three years. Next survey will be in 2000; Hospital is also certified by the Health Care Financing Administration (HCFA);

- Continued to renovate a patient lodge, per year, to update the physical environment to include automatic sprinklers, magnetic lock egress, and general upgrades (work was recognized and commended by national, federal, and state regulatory agencies). Given approval to bid on two (2) lodges at a time to expedite renovation process;

- Crisis programming successfully reduced recidivism rate for short stay population. The crisis unit admitted 43.6% of all patients. The 30 day recidivism rate was 5.2% compared to 10.%% in all other lodges;

- Total seclusion hours decreased from 2320 hours in FY99 to 830.75 hours in FY00. Total restraint hours decreased from 64.25 hours in FY99 to 16.25 hours in FY00;

- The patient satisfaction survey exceeded the 85% threshold on all items throughout the year;

- The Brief Psychiatric Rating Scale was completed on 55 patients during June 2000. There was a 54% reduction of psychiatric symptom from admission to discharge for this sample; and

- The average length of stay has increased because of unavailability of long term psychiatric beds.

Program Title: **Patrick B. Harris Psychiatric Hospital**

Program Rank: 2-b

Program Cost:

State	**$12,281,005**
Federal	
Other	**$1,550,062**
Total	**$13,831,067**

Note: Figures represent direct costs only, excluding Fringe Benefits and other DMH-allocated expenditures

Program Goals: The goal of this 206-bed hospital is to provide intensive, short-term psychiatric care to citizens from the 13 counties of upstate South Carolina. This public inpatient facility provides 24-hour emergency voluntary and involuntary psychiatric patient care for the geriatric, adult and adolescent communities needing its services. Specialized programs for substance abuse disorders and the hearing-impaired (state-wide) are also provided. All patients are served on the basis of clinical need, and no patient is denied services on the basis of ability to pay.

Program Objectives:

1) To demonstrate hospital commitment to excellent inpatient care:

   a. by performing continuous internal assessment of patient care provided by competent professional, administrative, and support staff; and

   b. by maintaining hospital performance standards that meet or exceed those standards rated by mandatory and voluntary surveys conducted by agency, state, and consumer organizations;

2) To ensure that capital expenditure planning required for improving the hospital environment for patients and staff, for maintaining its physical assets and for improving the hospital's efficiency and effectiveness is an integral part of the budget formulation and expenditure process;

3) To manage human, financial, technological and other resources in a manner that best serves consumer needs;

3) To support all toward-local-care (TLC) initiatives that have been identified by the SCDMH Mental Health Commission, State Director, and Transition Leadership Council.

Program Results:

- The hospital maintained accreditation and was re-accredited in June 2000 for three years by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO);

- The hospital was in compliance with all mandatory and voluntary surveys conducted by agency, state and consumer organizations;

- The hospital maintained adult psychiatric services for patients 18 years of age and older;

- The hospital maintained its substance abuse program for adult patients 18 years and older;

- The hospital took steps to increase substance abuse education and treatment within the adolescent psychiatric services offered;

- During Fiscal Year (FY) 1999-2000, the hospital implemented an intermediate care program with life skills training to increase the likelihood of successful community adjustment for the seriously mentally ill. Success of this program will be reflected in reduced number, frequency and length of readmissions of these patients. Average length of stay for the intermediate care program was 66.7 days for this 44-bed unit. Special discharge planning resulted in an average of 16 patients per month being discharged from intermediate care. In previous years, some of these longer-term patients would be six months or more in acute care, mixed with patients who are discharged in 15 days or less;

- The hospital provided care to 2,223 (+ 0.5%) adult psychiatric admissions, 273 adolescent admissions (+ 18%), and 844 (- 13%) substance abuse program admissions (change FY00 compared to FY99). An average of 35 substance abuse patients were in the program each day. One-third to one-half of all psychiatric admissions involved substance abuse;

- Patient admissions during FY00 remained about the same as the previous fiscal year. Patient admissions repeatedly have reached a plateau and climbed: FY94, FY95, and FY96 formed a plateau that averaged 1,700 annual admissions; FY97 & FY98 jumped to 2,900 admissions annually; and FY99 & FY00 plateaued at 3,300 - 3,400 admissions; and

- During FY00, the hospital completed a major pharmacy renovation and expansion. Other capital improvement projects included patient safety evacuation walkways, regulatory signage and exterior maintenance vinyl siding trim. Work continues regarding ADA renovations in the lobby, bathrooms, and family counseling rooms.

Program Title: William S. Hall Psychiatric Institute

Program Rank: 3

State	**$13,835,365**
Federal	**$19,882**

Other	**$11,752,633**
Total	**$25,607,880**

Note: Figures represent direct costs only, excluding Fringe Benefits and other DMH-allocated expenditures

Program Goals: The goal of this facility is to provide high quality patient- centered psychiatric services for the South Carolina Department of Mental Health and the citizens of South Carolina.

Program Objectives:

1) To continuously seek ways to improve the quality of services provided our customers using a Quality Improvement approach;

1) To maintain compliance with and certification from regulatory agencies both sate and federal;

1) To maintain accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO);

1) To provide a quality training platform for residency and fellowship programs in general, child, adolescent and forensic psychiatry; and

1) To engage in education, training and research initiatives within the SCDMH.

Program Results:

All programs maintained licensure/certification through the Department of Health and Environmental Control (DHEC) and Health Care Finance Administration (HCFA).

On January 10, 2000, a Treatment Mall concept was initiated in the Allan Project. The purpose of this initiative is to provide active treatment of patients using a psycho social rehabilitation approach. The program has been extended and all patients in the Allan Project are screened and placed in appropriate group therapy.

The Forensic Division has successfully recruited highly qualified professional staff.

An External Forensic Review Board was established to provide a review of all patients recommended for discharge from the Allan Project. The panel includes a DMH legal representative and a community representative.

The facility has embarked on providing Telemedicine Consultative Services to interested parties within DMH and the corrections systems. Agreements are in place and the program will be expanded as need dictates.

A family court clinic has been established to help meet the needs of children with legal issues.

WSHPI continues to participate in DMH's outcomes and JCAHO Oryx initiatives.

Patient Satisfaction Surveys are administered to patients upon discharge and consistently reflect positive customers satisfaction.

Quality Improvement Teams are used to address opportunities for improvement within the Institute. These teams are multidisciplinary, outcome focused and time limited. Improvements made within the Institute as a result of work of the QIT's include:

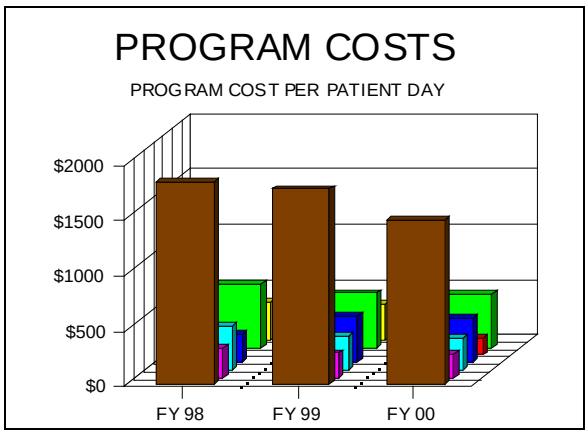
- Improved reporting of medication errors;
- Sustained reduction of seclusion/restraint;
- Cultural competence training for staff;
- Portable emergency kits; and
- Peer review process for physician.

PERFORMANCE MEASURES:

WORKLOAD	FY 97-98	FY 98-99	FY 99-00
Total patient received	1,032	1,165	1,266
Total patients separated	1,027	1,138	1,263
Average daily census	231	238	223
Average length of stay	43	55	90
Year end census	232	258	225
Cost of average length of stay*	$14,459	$16,754	$23,085

PROGRAM COSTS			
Program Cost Per Patient Day	**FY 97-98**	**FY 98-99**	**FY 99-00**
Young Adult Program (YAP)	$341.29	$329.39	Unit Closed
Child & Adolescent (C&A)	$577.50	$494.45	$400.64

Adolescent Drug Alcohol Program
Directions
Options
Forensic
Total Inpatient



*Cost of average length of stay is:
(Average Length of Stay multiplied by the Total Inpatient Cost Per Day)

- The cost per patient day for Directions increased in FY 99-00. This increase was due to a decrease in the program's average daily census.
- The overall program costs for WSHPI decreased in FY 99-00.
- The Adolescent Drug & Alcohol program opened on Feb. 1, 1999.

Program Title: DIVISION OF PSYCHIATRIC REHABILITATION SERVICES
South Carolina State Hospital

Program Rank: 4

Program Cost:

State	**$13,298,790**
Federal	
Other	**$11,364,706**
Total	**$24,663,496**

Note: Figures represent direct costs only, excluding Fringe Benefits and other DMH-allocated expenditures.

Program Goals: To provide quality rehabilitative and long term psychiatric inpatient services for the adult and geriatric populations.

Program Objectives:

1) to provide professional services that address the psychiatric, physical, social and other clinical needs of the patient population by means of psychosocial rehabilitation programs, recreational therapy and employment opportunities;
1) to continue to assess the treatment delivery system to meet the ever-changing identified patient needs;
2) to promote the treatment partnership process and positive communication between patients and staff; and
3) to work in partnership with other DMH and community mental health services to provide a continuum of appropriate and effective health care services and a seamless transition of patients discharged to the community.

Program Results:

Work Load:	**FY98**	**FY99**	**FY00**
Total patients received:	176	217	126
Total patient separated	210	184	174
Average length of stay(D/C)	720.5 days	682.5 days	643.0 days
Average daily census	361	356	367
Year end census	346	367	311
Functional bed capacity	370	376	338

- Admission and discharge functions were consolidated and centralized at William S. Hall Psychiatric Institute.
- SCSH stopped receiving patient transfers from the acute psychiatric facilities in March 2000 in an effort to down-size and close one patient building.
- Ward 170, Preston Building, was transferred to William S. Hall Psychiatric Institute (nol prosse patients) in June 2000.
- Ward 172, Preston Building was vacated and the patients absorbed into other vacant beds within SCSH in June 2000.
- Ward 168, Preston Building was vacated and the patients absorbed into other vacant beds within SCSH in August 2000.
- Patients readmitted within 90 days of discharge was only one (1) for FY 1999-2000
- Psychiatric symptomatology is measured on each patient upon admission, annually and at discharge using the Brief Psychiatric Rating Scale (BPRS). Overall scores for FY 1999-2000 demonstrate 7.5 points improvement in symptoms.
- Functional level of each patient is measured upon admission, annually and at discharge using the McCarter Functional Scale. A database has been created to track functional issues.

- Treatment teams are provided individual patient profiles of symptomatology and functional level at the time of annual assessment.
- The Psychosocial Rehabilitation Program has provided or is in the process of providing Liberman training to the community at four mental health centers and one correctional institution.
- Community needs assessment conducted during the annual "Walk for the Mentally Ill" indicated a 1 (1 to 5 scale with 1 being most positive) with services provided by SCSH.
- Satisfaction measured during "Family Day" averaged an 80% favorable rating with services provided by SCSH.
- Satisfaction surveys of clinical services provided were conducted among the patient population using a 1 to 5 Likert scale (with 1 being the most positive) yielded the following results: Psychosocial Rehabilitation - 1; Kiva - 1; Nursing - 1.8; Activity Therapy - 2.5 and Social Work Service - 2.6.

Program Title: Earle E. Morris, Jr., Alcohol & Drug Addiction Treatment Center

Program Rank: 5

Program Cost:

State	**$6,842,995**
Federal	
Other	**$2,387,192**
Total	**$9,230,187**

Note: Figures represent direct costs only, excluding Fringe Benefits and other DMH-allocated expenditures

Program Goals:

To provide effective and efficient treatment of alcohol and other drug dependency. The facility serves persons 18 years of age and older who are chemically dependent and meet the criteria for inpatient treatment established by the American Society of Addiction Medicine. Specialized services are provided for adult women, adult men, and persons with a dual diagnosis of substance abuse and mental illness. Morris Village, in collaboration with the William S. Hall Psychiatric Institute, also operates a 22-bed therapeutic community for treatment of adolescents with substance abuse problems.

Program Objectives:

1) Identify and minimize barriers to accessibility;
2) Continually assess the treatment needs of persons with a substance dependence and design services to meet those needs to the extent possible;
3) Provide effective and efficient inpatient treatment services and maintain systems that assess effectiveness and efficiency of services; and
4) Strengthen links with community resources so that persons leaving the inpatient setting have access to services in their home communities.

Program Results:

In October of 1999, Morris Village, in collaboration with Columbia Area Mental Health Center (CAMHC) and the Lexington/Richland Alcohol and Drug Abuse Council (L/RADAC), implemented a crisis stabilization project for men from Richland and Fairfield counties. The project was designed to divert individuals who present with alcohol and other drug problems and would be involuntarily committed to Bryan Psychiatric Hospital (BPH) if no bed were available at Morris Village. Twelve beds at Morris Village were designated for the project. A major objective was to increase accessibility for individuals from the target area. Three strategies were employed to increase accessibility:

1) Increase the number of patients who were admitted voluntarily by providing transportation for voluntary patients and allowing immediate admission (no waiting list);

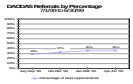
1) The treatment team was encouraged to step patients down to a lower level of care, L/RADAC, as soon as they were stabilized; and

1) A Steering Committee that included representation from L/RADAC, BPH, CAMHC, the Richland County Probate Judge and member of the Morris Village treatment team began meeting regularly to identify problems and ways for the project to work more effectively.

In the first nine months of implementation, the number of males from Richland County sent to BPH decreased by 32%. Although there were a number of factors that influenced this drop in admissions among the target group, it is safe to say that the Crisis Stabilization Project was a major contributing factor.

Morris Village continued to implement treatment outcomes protocols to assess the effectiveness of treatment services. Outcomes data indicated that persons treated in the program experienced a 94% decrease in the number of days of alcohol use in the 30 days following treatment as compared to the 30 days before treatment. There was a 84% decrease in the number of days for use of alcohol and drugs in the 30 days following treatment as compared to the 30 days before treatment.

Morris Village continues to work with the Department of Alcohol and Other Drug Abuse Services to ensure that persons completing treatment at Morris Village successfully transition to outpatient care provided by the community alcohol and drug treatment providers. The graph illustrates the percentage of patients who are discharged from DMH hospitals who are referred to DAODAS providers and keep their first appointment.



Program Title: **BYRNES CENTER**

Program Rank: 6

Program Cost:

State	**$4,616,045**
Federal	
Other	**$251,469**
Total	**$4,867,514**

Note: Figures represent direct costs only, excluding Fringe Benefits and other DMH allocated costs.

Program Goals:

1) to provide inpatient infirmary level of care;
2) to provide urgent/emergent and ambulatory preventive, consultative and primary medical care to patients receiving psychiatric treatment in DMH"s other Columbia inpatient facilities; and
3) to provide diagnostic services not only for Byrnes inpatient services, but to support medical and psychiatric management to other DMH facilities and centers.

Program Objectives:

1) to continually evaluate system needs and streamline service delivery;
2) to enhance ambulatory care services into an efficient preventive medical model; and
3) to maximize reimbursement services.

Performance Measures:

Work Load:	**FY98**	**FY99**	**FY00**
Total admissions	618	459	225
Total discharges	595	501	202
Average daily census	31	21	11
Inpatient days	11,315	7,139	4,076
Ambulatory Clinic visits	5,883	5,352	3,831
Urgent Care visits		1,381	745
Laboratory (clients served)		29,896	23,888
Radiology (clients served)		3,912	3,054
Physical therapy (client visits)		1,684	1,594
Dental(clients served)		2,675	2,316
EKG/EEG (procedures)		1,324	960

Program Outcomes:

- Contracted services with USC Specialty Group for the Ambulatory Care Clinic;
- Reorganized the Ambulatory Care Clinic Office to include an office manager/coder to enhance reimbursement; and
- Laboratory passed their CLIA inspection.

Program Title: C.M. Tucker/Dowdy-Gardner Nursing Care Center

Program Rank: 7

Program Cost:

State	**$8,476,661**
Federal	**$3,812**

Other	**$14,439,568**
Total	**$22,920,041**

Note: Figures represent direct costs only, excluding Fringe Benefits and other DMH-allocated expenditures

Program Goals: To provide skilled and intermediate long term nursing care to persons who are mentally/physically handicapped whose needs cannot be met in other private or public facilities

Program Objectives:

1) To provide excellence in resident care in an environment of concern and compassion;
2) To provide a comfortable and safe human habitat with resident focused activities; and
3) To improve quality of life by eliminating the loneliness, hopelessness, and boredom that plague our elders**.**

Program Outcomes:

1) appointed pain management task force to enhance pain assessment and intervention;
2) adopted the Eden Alternative principles to provide the variety and spontaneity that mark an enlivened environment;
3) achieved successful DHEC/HCFA certification survey at the Harden Street campus;
4) closed the Farmer Building in February, transferring the remaining residents to C.M. Tucker;
5) established a task force to address placement of residents based on clinical needs;
6) achieved successful survey by the Joint Commission on Accreditation of Healthcare Organizations in June 2000;
7) achieved successful survey of the Stone Pavilion by the Veterans Administration in February 2000;
8) completed first phase of HVAC replacement in the Roddey Pavilion; and
9) implemented respite services for elderly cared for in the community.

Program Title: **Campbell Veterans Nursing Home**

Program Rank: **8**

Program Cost:

State	**$3,367,003**
Federal	
Other	**$5,046,456**
Total	**$8,413,459**

Note: Figures represent direct costs only, excluding Fringe Benefits and other DMH-allocated expenditures

Program Goals: To provide appropriate quality care services to eligible veterans who require intermediate and skilled nursing care

Program Objectives:

1) to provide excellence in resident care in an environment of concern and compassion;
1) to serve the medical and spiritual needs of the veterans; and
3) to maintain licensure and certification in addition to meeting Veterans Administration standards.

Program Results*:*

1) achieved successful survey be the Veterans Administration in June 2000;
2) enriched the human habitat with plants and animals and offered training to employees and families on the Eden principles;
3) erected a pavilion by the lake to provide a shaded area for fishing and outdoor recreation;
4) refurbished the front lobby of Campbell to reflect a warmer, more home-like environment;
5) obtained contract for provision of dental and optometry services;
6) implemented the First Source Quality Assurance Program to systematically and objectively monitor and evaluate resident care; and
7) operated the facility within authorized budget.

Program Title:INTERMEDIATE CARE FACILITY/MENTAL RETARDATION (ICF/MR)

Program Rank: 9

Program Cost:

State	**$832,966**
Federal	
Other	**$2,447,023**
Total	**$3,279,989**

Note:**Figures represent direct costs only, excluding Fringe Benefits and other DMH allocated expenditures.**

Program Goals:to provide rehabilitation and health care for developmentally impaired clients who have a diagnosis of mental retardation with a co-existing mental illness.

Program Objectives:

1) to provide individually designed programs for the client that are based on the developmental model through a multidisciplinary approach to resemble as closely as possible conditions of every day life in mainstream society; and
2) to maintain DHEC certification which insures that the program meets quality standards.

Program Outcomes:

Work Load:	**FY98**	**FY99**	**FY00**
Total patients admitted	4	5	3
Total patients separated	6	6	9
Average daily census	51	51	51
Year end census	50	50	50
Functional bed capacity	55	55	55

1) Maintained DHEC certification;
2) Assessed program effectiveness and discontinued the “A-Team” program (a program specializing in behavior modifications for the most difficult clients) and the “Independent Living Program”;
3) Revised the vocational program, “Work Experience” program, consisting of horticulture therapy, paper sorting and shredding, sorting of nuts and bolts and dinnerware packaging. All vocational training now takes place on campus, with no clients working in the private sector; and
4) Re-implemented the Special Olympics program.

Program Title: **Behavioral Disorders Treatment Program (Sexually Violent Predator Program)**

Program Rank: 10

Program Cost:

State	**$1,792,860**
Federal	
Other	
Total	**$1,792,860**

Note: Figures represent direct costs only, excluding Fringe Benefits and other DMH-allocated expenditures

Program Goals: The goal of the Behavioral Disorders Treatment Program is to comply with the South Carolina Law - Chapter 48, Code Section §44-48-10 through §44-22-10(11), which mandates the Department of Mental Health to provide treatment for individuals committed as sexually violent predators. Located within the confines of the South Carolina Department of Corrections, the program is mandated to provide for the safety of the public while providing effective treatment interventions in a humane manner consistent with the general operating procedures of the Department of Mental Health.

The statute also provides for the Department of Mental Health to have a prominent role in the function of the Multi-disciplinary team which provides initial screenings for individuals contemplated for commitment under the statute.

In addition, although not mandated by the statute, the courts have assigned DMH the added responsibility of providing pre-trial evaluations for individuals who are being considered for commitment.

Program Objectives:

By recruiting and training an array of professional and non-professional staff members, the Behavioral Disorders Treatment Program provides diagnostic and treatment services consistent with other programs of its type around the country. In addition, the DMH has developed a diagnostic laboratory capable of providing specific testing to evaluate referred individuals for the presence of sexually deviant arousal patterns.

A DMH security force dedicated to the program provides for the safety of staff, residents, and the general public.
A full-time psychologist with extensive expertise in the diagnosis and treatment of individuals with sexual disorders has been recruited to provide guidance and education to the other members of the Multi-Disciplinary Team.

In addition, the department has contracted with the University of South Carolina School of Medicine and with privately practicing psychiatrists to provide pre-trial evaluations. Revenue contracts have been signed between DMH and these providers which allow our contractors access to the department's diagnostic laboratory in exchange for a fee payable to the department**.**

Program Outcomes:

Through the end of FY 00, 947 individuals have been reviewed for possible commitment the Multi-Disciplinary Team and, of these, 396 individuals have been referred further into

the commitment process.

The department has arranged for forty-four (44) individuals to have pre-trial evaluations, and bears the costs associated with these evaluations, and any subsequent court room testimony.

Of the 44 individuals who have stood trial to for commitment as a sexually violent predator, 24 have been civilly committed and admitted to the program for treatment. Through the diligent efforts of our Public Safety Officers, there have been no significant security related events since the program's inception.